Care Quality Commission

Inspection Evidence Table

Botley Medical Centre (1-544081039)

Inspection date: 7 April 2021

Date of data download: 18 March 2021

At our previous inspection in October 2019, we found concerns regarding the monitoring of high-risk medicines and the implementation of policies. We issued requirement notices and a rating of Requires Improvement overall. We also asked the provider to consider how to improve their cervical screening monitoring.

At this inspection, we found significant risks to patients, which were caused by a lack of adequate governance processes. We have now rated the practice as Inadequate overall.

Overall rating: Inadequate

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe Rating: Inadequate

At our previous inspection we identified concerns regarding the monitoring of high-risk medicines. We rated the domain as Requires Improvement.

At this inspection, we found further concerns regarding high risk medication monitoring and due to broader search criteria on the clinical system, identified extensive concerns. We found clinical records were not maintained appropriately to ensure patients were able to have their care monitored safely. Medicine safety alerts were not acted on to keep patients safe. Staff were not always trained or inducted in subject areas required for their roles. We have rated the practice as inadequate in this domain because people were at risk of harm due to the concerns we identified.

Safety systems and processes

The practice did not have systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	No
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	No
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: Reception staff were not always formally inducted, were not provided with safeguarding policies, and we found gaps in safeguarding vulnerable adults and children training. Two out of three members of the reception team we spoke with were not provided with safeguarding adults or children training. There was a risk non-clinical staff did not understand the practice's safeguarding protocols or have the understanding to identify indicators of potential abuse and how to report any concerns.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	No
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial
Explanation of any answers and additional evidence: The practice did not maintain a system to ensure staff checks such as registration with professional bodies or any vaccination boosters were undertaken periodically.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: March 2021	Yes
There was a record of equipment calibration. Date of last calibration: Not provided (verbal confirmation only)	No
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes

There was a record of fire extinguisher checks. Date of last check: January 2021	Yes
There was a log of fire drills. Date of last drill: April 2020	Yes
There was a record of fire alarm checks. Date of last check: January 2021	Yes
There was a record of fire training for staff. Date of last training: various	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: March 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: The practice informed us that calibration had been undertaken on equipment as required in the last 12 months. We requested the related records to verify this on three occasions but they were not shared with us.	

Health and safety	**Y/N/Partial**
Premises/security risk assessment had been carried out. Date of last assessment: March 2021	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various assessments related (this relates to COSHH, premises risk assessments, legionella and others).	Yes

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: March 2020	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: The practice had undertaken an additional Covid 19 related infection control audit provided by the local Clinical Commissioning Group (CCG) during the pandemic to ensure procedures were safe for protecting staff and patients. The annual infection control audit was slightly overdue and the practice acknowledged this needed to be completed. Staff training was not monitored appropriately to ensure all staff undertook infection control training.	

Risks to patients

There were no adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	No
Comprehensive risk assessments were carried out for patients.	No
Risk management plans for patients were developed in line with national guidance.	No
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	No
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
Explanation of any answers and additional evidence:	

Staff were not always provided with inductions. We spoke with three members of the reception team and they informed us they had not received full formal inductions. Two of the receptionists we spoke with informed us they had not been made aware of the tools available at reception for prioritising patients based on the symptoms or concerns that patients may present to staff on telephone calls or in person. We found there were tools available in reception to assist staff in assessing the urgency of patients' needs, but they were not clearly displayed. The reception staff informed us they had not been provided with training on understanding symptoms associated with sepsis. When we observed the reception team's working area, we found information regarding sepsis had been displayed on walls.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	No
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	No
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	No
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

Explanation of any answers and additional evidence:

Patient records were not monitored appropriately to ensure that clinical tasks were acted on. For example, we found instances where test results requiring actions by clinicians to ensure patient safety, were filed on patient records without any action being recorded.

Shared care agreements (sometimes required when care is shared between external services and GP practices) were not always in place when needed. For example, patients who were under the shared care arrangements between hospitals and the practice, did not always have shared care agreements on their clinical records. This posed a risk that patients would not have their care effectively monitored and we identified risks as a result of this finding, such as poor monitoring of high-risk medicines.

Appropriate and safe use of medicines

The practice did not have effective systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHS Business Service Authority - NHSBSA)	0.71	0.67	0.76	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2020 to 31/12/2020) (NHSBSA)	12.2%	11.7%	9.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2020 to 31/12/2020) (NHSBSA)	4.37	5.24	5.33	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	55.5‰	88.9‰	127.0‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHSBSA)	0.47	0.44	0.67	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	No
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	No
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes*

Explanation of any answers and additional evidence:

During our last inspection in October 2019 we identified the monitoring of high risk medicines was not appropriate. There were risks associated with the medicines prescribed that were not being monitored and mitigated where required.

During this inspection we undertook extensive remote (offsite) searches on the practice's clinical systems. This identified that there were patient records with no up to date recording of reviews of their medication. We reviewed the individual records of patients prescribed the medicines included in our broader clinical searches. The provider had not ensured that medicines were prescribed safely on an ongoing basis. For example:

-60 out of 269 patients on Direct Anticoagulants (DOACs) (prescribed to reduce the risk of blood clotting) had no creatinine clearance (required to monitor kidney function) level check since starting the medicine and 168 had not had a blood test to monitor creatinine clearance in the last 12 months.

-The clinical searches identified 61 patients who had been prescribed Methotrexate (an immunosuppressant used to slow or suppress the body's immune response) in the six months preceding the search; none of the 61 patients were coded as having received the necessary monitoring on the clinical system. We reviewed five of these patients' individual care records and found four had not been appropriately monitored and were at risk due to this lack of monitoring.

Medicines management	Y/N/Partial
-There were 22 patients being prescribed Lithium (for the treatment of specific mental health conditions). None of these patients were indicated as having up to date reviews of their Lithium prescribing. We reviewed five patient records from this specific search and found all of them were at risk due to overdue monitoring reviews of their prescribing. -Our clinical searches identified 68 patients on Warfarin (an anticoagulant, or blood thinning medicine) and indicated 17 were overdue monitoring. Through further analysis, we identified examples of inappropriate ongoing prescribing due to the risk of a lack of monitoring and inappropriate dosage being prescribed as stated by national guidance on the prescribing of these medicines. - We identified 11 patients prescribed Short-Acting Beta-Agonists (SABAs) who had a diagnosis of Asthma who had been prescribed more than 12 SABA inhalers. This indicated poor control of the patients' conditions and a risk of overprescribing the medicine. *The practice had a vaccine fridge plugged into a wall socket which was exposed to passers by and there was a risk it could have been accidentally switched off. There was a warning sign above the socket as the risk had been identified. However, the fridge had been turned off accidentally in the days before the inspection and appropriate action had been taken to ensure compromised vaccines were not used. The fridges were monitored appropriately to ensure they were operating within required temperature ranges. The practice had successfully reduced prescribing in two areas (see tables above), which indicated responsible prescribing of specific anti-biotics and specific pain medications.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 6 months:	8
Number of events that required action:	8

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
Patient was not contacted for a blood test following discharge from hospital.	The GPs reviewed the system for such a follow up and considered changes that may be required. However, we found concerns regarding actions following some blood tests.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	No
Staff understood how to deal with alerts.	No

Explanation of any answers and additional evidence:

Medication safety alerts were not always acted on to ensure patients were protected from potential harm. From clinical searches, we identified 43 patients prescribed Omeprazole and Clopidogrel (intended to reduce the risk of heart disease and stroke). Following the Medicines and Healthcare products Regulatory Agency (MHRA) alert, these medicines should not be taken together as Omeprazole reduces the antiplatelet activity of Clopidogrel and could increase the risk of strokes or myocardial infarction (heart attack).

There were 12 patients on Hydrochlorothiazide (diuretic or water pill that helps prevent your body from absorbing too much salt) and out of five patient records we reviewed, there was no record that they had been advised by the practice that there was a potential risk of skin cancer when taking this medicine.

Effective Rating: Requires improvement

At our previous inspection we rated this domain as good. At this inspection we found concerns regarding monitoring patient care, staff training and assessing patients' needs and have rated the domain as requires improvement.

Effective needs assessment, care and treatment

Patients' needs were not always assessed. Patient care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	No
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence: We found from remote clinical searches that patients with potentially undiagnosed conditions were not monitored appropriately. This included patients with potential undiagnosed chronic kidney disease and diabetes. There was a risk to these patients due to a lack of monitoring. We found that patients on the mental health register did not always have their care plans updated by the practice. These patients may not have had care needs assessed and monitored.	

Older people

Population group rating: Requires improvement

Findings

- The lack of appropriate monitoring of ongoing care tasks such as medication reviews, posed a risk to all population groups.
- The practice had been administering Covid 19 vaccinations in the months preceding this inspection. They had been prioritising and contacting the oldest patients first in line with the national programme of vaccination.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires improvement

Findings

- The lack of appropriate monitoring of ongoing care tasks such as medicine reviews, posed a risk to all population groups.
- Patients with long-term conditions did not always attend a structured annual review to check their health and medicines needs were being met. Staff informed us some patients were concerned about attending the practice due to the risk of Covid 19. Due to this risk, respiratory reviews such as chronic obstructive pulmonary disease (COPD) and asthma were limited.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice did not appropriately monitor patients with potentially undiagnosed conditions, for example diabetes and chronic kidney disease.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	73.0%	77.3%	76.6%	No statistical variation
PCA* rate (number of PCAs).	4.2% (39)	12.2%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in	94.9%	91.1%	89.4%	No statistical variation

the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)				
PCA rate (number of PCAs).	18.2% (44)	14.2%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	89.2%	83.3%	82.0%	Tending towards variation (positive)
PCA rate (number of PCAs).	24.2% (68)	4.6%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	63.4%	66.5%	66.9%	No statistical variation
PCA rate (number of PCAs).	9.4% (61)	14.6%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	59.6%	72.2%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	9.2% (147)	6.3%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	90.4%	91.0%	91.8%	No statistical variation
PCA rate (number of PCAs).	8.8% (29)	5.3%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	54.4%	77.0%	75.9%	Variation (negative)
PCA rate (number of PCAs).	12.7% (82)	10.1%	10.4%	N/A

Any additional evidence or comments
We were provided with the practice's unverified QOF performance for 2020/21. This indicated that the practice had achieved 73% of its QOF points for hypertension care and 89% for secondary prevention of coronary heart disease. The data showed the practice achieved 100% of its QOF points for diabetes.

Families, children and young people

Population group rating: Requires improvement

Findings

- The lack of appropriate monitoring of ongoing care tasks such as medication reviews, posed a risk to all population groups.
- The practice met the minimum 90% for three of four childhood immunisation uptake indicators. One indicator was 3.5% below the minimum target. The practice did not meet the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and liaised with health visitors when necessary.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	96	111	86.5%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	124	135	91.9%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	125	135	92.6%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	125	135	92.6%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	159	172	92.4%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- The lack of appropriate monitoring of ongoing care tasks such as medication reviews posed a risk to all population groups.
- Vaccinations and health screening were available for patients of working age.
- The practice had been proactively contacting patients in order to improve the uptake of cervical screening. GPs and the lead nurse informed us the practice had been writing to and texting patients to prompt them to attend for cervical screening. Unverified public health QOF data indicated that the practice had achieved 15 out of a maximum 22 (68%) QOF points (determined by the number of eligible patients) for cervical screening in 2020/21.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 30/09/2020) (Public Health England)	66.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	71.7%	72.3%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) (PHE)	65.8%	N/A	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	100.0%	95.0%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	70.8%	65.5%	54.2%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- The lack of appropriate monitoring of ongoing care tasks such as medication reviews posed a risk to all population groups.
- Same day appointments and longer appointments were offered when required.
- Patients with a learning disability were offered an annual health check. The practice had identified poor uptake for the health checks in 2019/20 and undertook an audit to assess the quality and improve uptake of the health checks.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- The practice did not always assess and monitor the physical health of people with mental health conditions. Care plans for this group of patients were not always up to date.
- There was not an adequate system for following up patients who required long term medication associated with their mental health.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected, there was an appropriate referral for diagnosis.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	94.1%	90.0%	85.4%	No statistical variation
PCA rate (number of PCAs).	9.9% (13)	15.9%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	82.3%	81.8%	81.4%	No statistical variation
PCA rate (number of PCAs).	6.8% (9)	5.1%	8.0%	N/A

Monitoring care and treatment

The practice had a programme of quality improvement activity. This did not fully identify and ensure necessary quality improvements.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	519.18	Not Available	533.9
Overall QOF score (as a percentage of maximum)	92.9%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	5.1%	Not Available	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	No
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

The practice sent us audits they had undertaken within the last year. This included an audit of rheumatoid arthritis which indicated that 49 patients were overdue a review of their condition in March 2020. The audit prompted 46 of these reviews to be completed within three weeks of the initial search.

We reviewed an audit used to identify the uptake of learning disability health checks. This also reviewed various screening and vaccination uptake in this group of patients. The practice had not repeated the audit but it had improved its uptake of health checks in 2021. Out of the 39 patients eligible for reviews, 34 had received their annual health check.

There was no effective audit to identify the monitoring of patients on high risk medicines. The practice had not implemented an effective system to ensure a breadth of clinical care tasks were being undertaken as required, such as action following blood tests.

Effective staffing

The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Partial
The practice had a programme of learning and development.	No
Staff had protected time for learning and development.	No
There was an induction programme for new staff.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial

Explanation of any answers and additional evidence:

Training was not monitored to ensure staff had the necessary competence, experience and skills to carry out their role. Reception staff interviewed informed us they had not received a formal induction when starting in their roles. Three members of staff had started working at the practice since September 2020 and all were assisting patients with appointment bookings and other patient requests regarding General Practice services. All three staff members informed us they had not undertaken information governance training and two informed us they had not undertaken either safeguarding vulnerable adults or children training. We looked at a report of staff training supplied by the practice during the inspection. The document corroborated our findings regarding a lack of induction training for reception staff. It also indicated that a healthcare assistant had not undertaken training in the Mental Capacity Act (2005).

Nurses had access to annual updates of training such as immunisations and cervical screening.

Staff reported not having protected time to undertake mandatory training.

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	No
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes

Explanation of any answers and additional evidence:

The practice communicated important care information with external providers, such as referral letters and received information from providers such as Out of Hours services.

We found shared care agreements were not always in place to ensure appropriate planning and monitoring of patients' care when shared between services.

Helping patients to live healthier lives

Staff were and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence: The practice was involved in the national programme of Covid 19 vaccination. They had a dedicated site for providing the vaccination clinics at their satellite location. This programme was resource intensive and required the practice to respond at short notice when vaccines were delivered in order to ensure patients were called and prompted to attend for their vaccines.	

Consent to care and treatment

The practice had processes to obtain consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: The practice had a policy for staff to ensure they adhered to the Mental Capcity Act (2005). However, not all staff providing care had undertaken the training required in relation to the Act.	

Well-led Rating: Inadequate

The practice was rated requires improvement for Well-led following an inspection in October 2019. This was due to not operating appropriate policies and procedures to ensure good governance of clinical care, specifically high-risk medicines monitoring.

At this inspection, we identified extensive governance risks and poor operation of policies and processes. Some staff reported a poor culture where some leaders were not approachable or visible.

Leadership capacity and capability

Leaders did not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	No
There was a leadership development programme, including a succession plan.	Partial
Explanation of any answers and additional evidence: Staff stated that they were not supported when they raised concerns about working processes. They did not feel able to approach some leaders or were discouraged from approaching some leaders. In discussions with some partners, there was a lack of awareness regarding the poor monitoring of patient care and the impact on patient safety. There was not sufficient quality improvement activity to identify areas where urgent improvements were needed.	

Vision and strategy

The practice had a clear vision but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	No
Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence:	

The practice had been affected by a loss of staff due to absences and staff moving on to other services. This compounded the pressure caused by the Covid 19 pandemic on the practice. In discussions with the Registered Manager at the end of the inspection, they were open about the fact these circumstances had inhibited the practice's ability to meet the challenges of improving patient care required, but that there had not been sufficient activity by leaders to ensure patient care was being delivered as they intended. They recognised the practice's need for external support. They acted swiftly to request support from the local healthcare system including commissioners and supplied CQC with an extensive and practical improvement plan.

As part of its strategy to improve before the inspection, the practice was trying to recruit clinical staff, practice management support and support staff. At the time of the inspection, a new clinical pharmacist was starting their employment with the practice.

There were meetings consisting of senior leaders where discussions regarding strategic decisions took place and aimed at identifying improvements.

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	No
There was a strong emphasis on the safety and well-being of staff.	No
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Partial

Explanation of any answers and additional evidence:

Many staff reported a culture which was divided between senior leaders and other staff groups. They felt unsupported and that communication was poor. They informed us that communications about changes or improvements were shared in a critical way and did not recognise the hard work and difficulties encountered by support staff. There was not always full consideration of risks posed to staff. Training intended to protect staff welfare at reception such as full infection control training was not always provided.

The practice provided evidence of an example of communication from the leadership team to staff members from January 2021, thanking them for their support in delivering the Covid 19 vaccination programme and informing them of how to report any concerns regarding Covid 19 infections.

Two members of staff reported feeling well supported by leaders in their role.

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff	Some staff reported feeling at risk of Covid 19 and not being supported when they reported this risk.
Staff	Two members of staff reported feeling well supported by the partners in their role.

Governance arrangements

The overall governance arrangements were not always effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	No
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:

We found partners were not aware of the poor performance regarding the monitoring of patients on high risk medicines, patients with potential undiagnosed conditions and that test results were not always being acted on. There was a lack of process and assurance through effective governance systems to identify these risks. The partners informed us that processes had been implemented since the previous inspection, which were intended to improve the monitoring of high-risk medicines. The registered manager acknowledged these processes required significant improvements as a result of seeing our findings.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: Staff working at reception were not always provided with the training they needed to ensure they could identify risks to patients. This included potential safeguarding, high risk conditions and ensuring patient data was handled appropriately. There were clinical audits in place being repeated to identify improvements. However, the audit systems did not effectively identify the clinical care risks identified by the inspection team.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	No
Our inspection indicated that information was accurate, valid, reliable and timely.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: We found that information received regarding patient care, such as test results, were not always acted on in a timely way. We found inaccurate information regarding patient care on the clinical system.	

Engagement with patients, the public, staff and external partners

The practice involved the public in how to identify improvements to services.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Partial*
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: *Please refer to previous evidence under the 'Culture' heading.	

Feedback from Patient Participation Group.

Feedback
The patient participation group members we spoke with stated that the practice had increased its engagement with them in recent months, following a period where engagement had been suspended after the start of the pandemic. They felt the practice's more recent engagement was positive. However, there was a concern raised about restriction of access to leaders and engagement being limited.

Continuous improvement and innovation

There was little evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence: There was a lack of systems and processes to identify necessary improvements and ensure that quality was assessed. Concerns identified to the practice by external organisations, including CQC were not always considered and acted on to ensure necessary improvements.	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease.
- **PHE**: Public Health England.
- **QOF**: Quality and Outcomes Framework.
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see GMS QOF Framework).
- ‰ = per thousand.